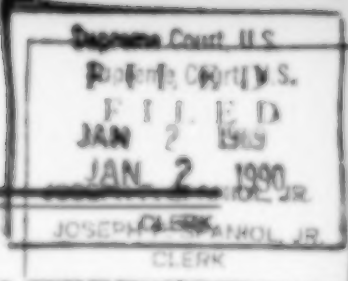


FOR ARGUMENT

No. 88-2043



IN THE  
Supreme Court of the United States

OCTOBER TERM, 1989

GERALD L. BALILES, et al.,

*Petitioners,*

v.

THE VIRGINIA HOSPITAL ASSOCIATION,

*Respondent.*

On Writ of Certiorari To the United States  
Court of Appeals For the Fourth Circuit

REPLY BRIEF FOR PETITIONERS

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REPLY BRIEF OF PETITIONERS

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The issue in this case is whether the Boren Amendment, Section 1396a(a)(13)(A) of the Medicaid Act as amended by § 2173(a) of the Omnibus Reconciliation Act of 1981, P.L. 97-35, gives Medicaid providers "enforceable rights" within the meaning of 42 U.S.C. § 1983 (1981) ("Section 1983") to payments by the states that are "reasonable and adequate" to meet the costs they actually incur in serving Medicaid patients. Both the existence of a right and the lack of foreclosure by a Congressionally preferred remedial scheme are essential prerequisites to the assertion of a right of action under Section 1983. Neither of these prerequisites has been met in this case.

ARGUMENT

I. THE BOREN AMENDMENT CREATES NO  
SUBSTANTIVE FEDERAL RIGHTS

The Respondent, Virginia Hospital Association ("the VHA"), argues alternately that, as amended by the Boren Amendment, Section 1396a(a)(13)(A): (1) gives Medicaid providers the right to "reimbursement

rates that are 'reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities,' Resp. Br. 4; (2) creates "a federal right on behalf of providers to be paid at rates which are reasonable and adequate to meet the costs incurred by efficiently and economically operated facilities," Resp. Br. 16; and (3) sets forth a requirement that "states participating in Medicaid . . . reimburse providers at the level established by the statute," Resp. Br. 46. In fact, Section 1396a(a)(13)(A) says and does none of those things.

As amended, Section 1396a(a)(13)(A) provides in pertinent part that a state plan for medical assistance must provide

for payment . . . of the hospital, skilled nursing facility, and intermediate care facility services provided under the plan through the use of rates (determined in accordance with methods and standards developed by the State . . . ) which the State finds, and makes assurances satisfactory to the Secretary, are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable State and Federal laws, regulations, and quality and safety standards and to assure that individuals eligible for medical assistance have reasonable access . . . to inpatient hospital services of adequate quality. . . .

By its terms, at most, this language requires only that participating states make *findings* that their reimbursement rates are sufficient to assure reasonable access to quality care and provide *assurances* satisfactory to the Secretary that they have done so.

To create secured and enforceable rights within the meaning of Section 1983, a statute must do more than state a "general prohibition or command" to be implemented by a state or federal agency, *University Research Ass'n. v. Contu*, 450 U.S. 754, 772 (1981).<sup>1</sup> It must confer

<sup>1</sup> Purporting to find in Section 1396a(a)(13)(A) "the imposition of binding obligations" Resp. Br. 17, quoting *Pennhurst*, 451 U.S. at 27, the VHA notes that under the statute "[a] state plan for medical assistance *must* provide for payment . . . of the hospital . . . services . . . ." Resp. Br. 13 (emphasis added). Like the Court of Appeals, see Pet. App. A7-A8, the VHA evidently believes that, by using the word "must," the statute effectively imposes mandatory obligations on the states, thus ensuring providers a "federal right . . . to be paid at rates which are reasonable and adequate." Resp. Br. 16. But the word "must" is not used in a vacuum. In this case, the word "must" introduces a clause that informs the states that to qualify for federal funds they must pay Medicaid providers using rates that the states find are reasonable and adequate to assure Medicaid recipients access to quality care. The word "must" does not, however, direct the states to pay any particular amount for services or to pay amounts providers deem to be reasonable. Yet, that is precisely what the VHA seeks.

"specific and definite" benefits, *Wright v. Roanoke Redevelopment & Housing Authority*, 479 U.S. 418, 432 (1987), in "right- or duty-creating language." *Cannon v. University of Chicago*, 441 U.S. 677, 690 n.13 (1979). Where, as here, the language does no more than compel a participating state to provide assurances, satisfactory to the Secretary, that it has made certain findings regarding the rates it pays Medicaid providers, there are no benefits conferred or enforceable rights created.<sup>2</sup> If a statute "confers no substantive rights, [the Court] need not reach the question whether there is a private cause of action under that [statute] or under 42 U.S.C. § 1983 to enforce those rights." *Pennhurst State School and Hospital v. Halderman*, 451 U.S. 1, 28 n.21 (1981), citing *Southeastern Community College v. Davis*, 442 U.S. 397, 404 n.5 (1979).

The language of the Boren Amendment serves the specific purpose of providing medical care to the needy, the only true purpose of the Medicaid program. 42 U.S.C. § 1396 (1985) (the purpose of the Medicaid Act is to enable each state as far as practicable under the conditions in such state to furnish health care to needy persons). To achieve this purpose, the Boren Amendment gives states the flexibility to determine what rates, within the context of state-specific health care cost environments, would be reasonable to meet the purpose of the program.

Beyond making assurances satisfactory to the Secretary that it has made such a determination (or "finding"), a participating state has no obligation under the Boren Amendment. Of course, the Secretary could and does seek further assurances if the assurances provided are not satisfactory to him, based on his own review of the assurances or his review of comments submitted by entities such as provider representatives. Nonetheless, nothing in the Boren Amendment can be construed

<sup>2</sup> The Boren Amendment is not phrased in terms of the interests of providers as the VHA agrees is required. Resp. Br. 24. Unlike the Housing Act Amendments at issue in *Wright*, which guaranteed tenants in Housing and Urban Development financed projects rents not exceeding "one-fourth of the family's income," 479 U.S. at 420 n.2, the Boren Amendment to the Medicaid Act removed the federal guarantee of reasonable cost reimbursement for providers and substituted, instead, state determined rates designed to effect cost-savings by requiring providers to "manage efficiently in order to remain in business." Statement of Honorable David L. Boren, U.S. Senator from the State of Oklahoma, Medicaid and Medicare Amendments: Hearings on H.R. 4000 (and All Similar Bills) Before the Subcommittee on Health and the Environment of the House Committee on Interstate and Foreign Commerce, 96th Cong., 1st Sess. 846 (1979) ("Boren Testimony").

to establish a right of sufficient specificity to be viewed as an enforceable right under Section 1983.<sup>3</sup>

The VHA acknowledges that the Commonwealth has made the findings required by the Boren Amendment and has given assurances satisfactory to the Secretary. Nonetheless, the VHA claims a violation of the Act "despite the assurances and findings of the Commonwealth of Virginia and the approval of the Secretary of Health and Human Services." J.A. 11 (Complaint ¶ 12) (emphasis added). What the VHA really seeks, then, is a right to be paid at rates which *the VHA*, not the State or the Secretary, believes to be reasonable.

The VHA's characterization of the statutory language ignores the text and reads out of the statute the measure of adequacy and reasonableness Congress explicitly provided: the existence of reasonable access to quality care and services for Medicaid recipients. Instead, the VHA seeks to substitute a financial standard for judging the reasonableness of rates — a standard that looks not to the adequacy and quality of services provided to recipients but to any disparity between payment rates and the costs reportedly incurred by efficient providers. There is no basis in the statute for such a claim.<sup>4</sup>

Rather than guaranteeing "economically and efficiently operated facilities" a *right* to reimbursement of the costs they actually incur in providing services as the VHA argues, the language of the Boren Amendment requires each participating state to make findings and provide assurances to the Secretary that the rates provided in its state plan do not exceed the rates necessary to "meet the costs which *must be incurred*" by efficiently run facilities in order to provide the level of care

<sup>3</sup> This Court left open in *Pennhurst* the question whether a statutory provision requiring "assurances" can ever be held to create an enforceable right under Section 1983, 451 U.S. at 28. Of course, this question need not be resolved in this case, as the subject of the assurances here is too indefinite to find an enforceable right even if assurances could give rise to a Section 1983 cause of action in and of themselves.

<sup>4</sup> As this Court noted in *Pennhurst*, "legislation enacted pursuant to the spending power is much in the nature of a contract: in return for federal funds, the States agree to comply with federally imposed conditions." 451 U.S. at 17. "The legitimacy of Congress' power to legislate under the spending power thus rests on whether the State voluntarily and knowingly accepts the terms of the 'contract'." *Id.* In agreeing to participate in the Medicaid program, the Commonwealth of Virginia accepted the terms of the statute, including the requirement in Section 1396a(a)(13)(A) that it make appropriate findings and give appropriate assurances to the Secretary. The VHA now proposes to change the terms of the contract, by replacing the agreed-to system of findings and assurances with a system of rates that it believes (or that it can convince a federal court to believe) are reasonable. The Commonwealth did not enter into such a contract.

and quality of services legally required for Medicaid patients. (Emphasis added.) Thus, the language of the Boren Amendment confers on the states the discretion to review the actual costs incurred by providers and to establish rates that compensate providers *only* for those costs linked to required care and services and, then, *only* at the rate necessary to assure recipient access to services.<sup>5</sup>

The Amendment does not guarantee providers the right to any particular level of payment. To the contrary, the purpose of the Boren Amendment was to encourage the states to establish payment rates based on findings regarding the costs that would be incurred by an "ideal" efficient and economic provider. The intent was to *force* efficiencies and permit states to introduce the law of supply and demand into the Medicaid system.<sup>6</sup>

<sup>5</sup> In a colloquy on the Senate floor at the time the 1980 Boren Amendment was under consideration, Senator Boren described the effect of the Amendment as follows:

[T]his amendment permits and encourages States to develop simpler more efficient ways of paying for nursing home care, including budget-based and negotiated rates. While it provides for the continuation of cost-reporting and auditing requirements for accountability, the amendment will not require States to rely exclusively on provider cost data in determining rates. Other independent measures of what services ought to cost could be used.

126 Cong. Rec. 17,885 (1980).

<sup>6</sup> Senator Boren testified in favor of the 1980 Boren Amendment applicable to nursing home rates that:

Federal regulations issued under [the pre-1980 statutory reimbursement provision] require that Medicaid rates be established directly on the basis of actual costs reported by nursing homes. The target of my amendment is this total dependence of the ratesetting system on cost reporting by the providers. Such a system gives no consideration to its effects on provider behavior and insufficient consideration as to whether reported costs are a proper reflection of what services ought to cost in view of other factors, including supply and demand.

To be sure, provider costs data comprise an important element of information in the ratesetting process. Under my amendment, States would continue to have access to that information as provided by various sections of the Social Security Act, including the Fraud and Abuse Control Amendments of 1977. A State would, however, be free to determine the degree to which it would rely on reported costs as a factor in ratesetting together with other relevant factors.

Boren Testimony at 846.

The VHA argues this case as if nothing much happened to Section 1396a(a)(13)(A) in 1980 and 1981. The VHA takes no account of the revised language of the Boren Amendment, nor does it explain how a statute that speaks only of "findings" and "assurances" can be converted into one that affords "a federal right on behalf of providers to be paid at rates which are reasonable and adequate to meet the costs incurred by efficiently and economically operated facilities." Resp. Br. 16. Moreover, the VHA is cavalier about the legislative history of the 1980 and 1981 amendments. In its view, the Boren Amendment — rather than working "a significant change in the federal [reimbursement] standard," *Wisconsin Hospital Ass'n v. Reivitz*, 733 F.2d 1226, 1228 (7th Cir. 1984), designed to give "the States flexibility and discretion . . . to formulate their own methods and standards of payment," S. Rep. No. 471, 96th Cong., 1st Sess. 28-29 (1979) — was essentially a continuation of past practice, reflecting, as the VHA puts it, "Congress's unchanged intention to require states to pay providers in accordance with the (now revised) statutory standards." Resp. Br. 13.<sup>7</sup>

Only by ignoring the fundamental change made by the Boren Amendment can the VHA make the arguments it does. The VHA relies heavily on a series of lower court decisions permitting private actions to enforce earlier versions of Section 1396a(a)(13)(A). Resp. Br. 7-9, 15 n.18.<sup>8</sup> It also cites 1975 legislation requiring participating states to waive their Eleventh Amendment immunity, as well as the 1976 provision repealing that waiver. Resp. Br. 10-11. But even if those authorities recognized an underlying Section 1983 cause of action — an assertion the Commonwealth disputes — the fact remains that the Boren Amendment explicitly, deliberately and substantially altered the basic statutory framework applicable to Medicaid payment systems.<sup>9</sup>

The VHA finds it "puzzling" that the United States, as amicus curiae, contends that Section 1396a(a)(13)(A) "does not require that rates be reasonable and adequate." Resp. Br. 14-15 n.17. The source of the VHA's puzzlement, however, is once again its failure to distinguish between the pre-1980 statute, under which rates had to reflect "reasonable cost," and the statute as amended, under which the states need only make "findings" that their rates are reasonable to assure access to needed services and quality care and give "assurances" satisfactory to the Secretary.

<sup>7</sup> The VHA offers no evidence, however, that Congress considered or approved any of the lower court decisions that it cites.

<sup>8</sup> The VHA contests the "bald assertion" of the United States that "some (unspecified) changes in the statutory language in the 1981 revision [in Section 1396a(a)(13)(A)] silently took away providers' right to sue." Resp. Br. 28. The "changes" in the statute —

(Continued on next page.)

As the Commonwealth and its amici explained at length in the opening briefs, the Boren amendments of 1980 and 1981 expressly revised Section 1396a(a)(13)(A) to *eliminate* a substantive requirement of "reasonable cost" reimbursement, and to replace it with the present formulation permitting states to make their own findings and assurances to the Secretary regarding the reasonableness and adequacy of payment rates in assuring reasonable access to quality care. That was a dramatic change in the legal landscape, designed intentionally to effect "more stringent cost containment," while freeing the states from excessive "federal oversight of [their] reimbursement methodologies." *Wisconsin Hospital Ass'n v. Reivitz*, 733 F.2d at 1228.

## II. THE ADMINISTRATIVE AND JUDICIAL REMEDIES IN THE MEDICAID ACT WERE INTENDED TO FORECLOSE PRIVATE ENFORCEMENT

A. Private enforcement of the Boren Amendment under Section 1983 is inconsistent with and destructive of the carefully tailored Medicaid scheme enacted by Congress.

The VHA argues that the Commonwealth has not met its burden of showing that Congress has foreclosed a Section 1983 remedy by creating a "comprehensive" alternative remedial scheme. Resp. Br. at 30-36. The VHA misconstrues the burden on the Commonwealth. We acknowledge the need to show foreclosure, Pet. Br. at 22-26, but dispute the VHA's contention that an intent to foreclose can only be found where Congress essentially has duplicated, in the statute in question, all of the remedies available under Section 1983.

Congressional intent to foreclose necessarily must be determined in the context of the underlying Congressional purpose of the statutory scheme under review and the nature of the federal right sought to be

(Continued from previous page.) hardly "unspecified" were the addition of the Boren Amendment language, altering Section 1396a(a)(13)(A) from a "reasonable cost" mandate to a mandate of "findings" and "assurances." The VHA recognizes the change in the law, Resp. Br. 28-29 n.28, but somehow concludes that "a comparison of the provider reimbursement provision in its 1972 and 1981 forms," Resp. Br. 28, demonstrates that nothing much happened for purposes of Section 1983 lawsuits. We do not understand — and the VHA does not explain — why the availability of a Section 1983 claim should not reflect the substantial overhaul in the underlying statutory right

enforced.<sup>10</sup> If a remedy were accorded a significance exceeding that of the right it is intended to protect, Congress' careful evaluation of the various competing interests, reflecting its legislative intent in creating a "right," would be ignored in defining the appropriate manner to enforce that wholly statutorily-derived right.<sup>11</sup>

Section 1983 "is a statutory remedy and Congress retains the authority to repeal it or replace it with an alternative remedy. The crucial question is what Congress intended." *Smith v. Robinson*, 468 U.S. 992, 1012 (1984) (citations omitted) (emphasis added). In reviewing Congressional intent, the critical question is whether private enforcement pursuant to Section 1983 would be inconsistent with a "carefully tailored scheme" enacted by Congress. *Id.* The test is not whether Congress has effectively duplicated the Section 1983 remedy elsewhere, but whether what Congress has done is sufficient to show an intent to foreclose private resort to federal courts under that Section. *Middlesex County Sewerage Authority v. National Sea Clammers' Ass'n*, 453 U.S. 1, 20 (1981).

If private Section 1983 enforcement would impair or work at cross purposes with the provisions of the Medicaid Act, such a remedy should not be available to enforce that Act. *Wright v. Roanoke Redevelopment & Housing Authority*, 479 U.S. at 423, citing *Smith v. Robinson*, 468 U.S. 992, 1012 (1984). Moreover, a broadly defined statutory standard should suggest Congressional intent to commit enforcement of

<sup>10</sup> Amicus Temple University, while acknowledging that the Boren Amendment does not require courts to engage in an independent determination of what Medicaid rates should be, suggests nonetheless that the Boren Amendment permits hospitals to challenge "arbitrary and capricious" payment systems. Assuming, arguendo, that the purpose of the Boren Amendment is to prevent states from establishing payment systems which are arbitrary and capricious, Congress' delegation of authority to the Secretary to review state payment systems is a logical and sufficient scheme to ensure a remedy for arbitrary state actions.

<sup>11</sup> The Medicaid program is a comprehensive political and legal framework for administration of a major national welfare scheme. Hospital reimbursement is one portion of a larger whole. Whatever affects one class of providers inevitably impacts the others. Litigation by one set of providers pursuing their unique and competing interests will negate the delicate balances struck by the states in fashioning their Medicaid programs. Diversion of limited state revenues to pay attorneys' fees for successful litigants inevitably will force cuts in the services provided for recipients. See 127 Cong. Rec. 19,097 (1981) (remarks of Senator Bradley) (the Boren Amendment "will allow [States] to achieve cost savings without imposing devastating cuts on the recipients of Medicaid services").

that standard to the exclusive discretion of the responsible administrative agency.<sup>12</sup>

The underlying purpose of the Boren Amendment was to give states the flexibility to determine payment rates that would assure continued access to quality care for recipients and to eliminate the inherently inflationary cost-based reimbursement system that preceded it. H.R. Rep. No. 158, 97th Cong. 1st Sess. 293 (1983). Congress provided that "the Secretary retains final authority to review rates and to disapprove these rates if they do not meet the requirements of the statute." H.R. Conf. Rep. No. 1479, 96th Cong. 2nd Sess., reprinted in 1980 U.S. Code Cong. & Admin. News 5903, 5944. At the same time, while Congress intended to assure state flexibility by limiting federal oversight of state payment systems, it was careful to provide that "the Secretary is not expected to approve a rate lower than the applicable legal requirements would mandate." *Id.* In defining those requirements, Congress explained that, since the Boren Amendment would free states from paying rates based on Medicare principles, the Secretary would only be expected to compare "aggregate amounts paid to hospitals." S. Rep. No. 139, 97th Cong. 1st Sess., reprinted in 1981 U.S. Code Cong. & Admin. News 396, 744-5. To permit individual private challenges to state payment systems would undermine the "aggregate test of reasonableness" which Congress intended to promote with the Boren Amendment. *Id.* at 745.

Consonant with the goals represented by the enactment of the Boren Amendment — state flexibility tempered by Secretarial oversight — Congress required states to submit their payment systems, in the form of state plan amendments, to the Secretary for approval and has given to the states the exclusive right to seek federal judicial review of state plan amendment disapprovals, as well as disallowances of federal matching funds by the Secretary. See 42 U.S.C. § 1315 (1983).

<sup>12</sup> Indeed, this Court has recognized in analogous circumstances that, where a statute provides no substantive standard upon which a court could base its review and "excludes" deference to the administrative agency charged with enforcing the statute, the language "strongly suggests that its implementation was committed to agency discretion by law" and forecloses "any meaningful judicial standard of review." *Wehster v. Doe*, 486 U.S. 592, \_\_\_\_ 100 L. Ed. 2d 632, 643 (1988) (statutory provision allowing agency director to terminate employee when he "deem[ed]" such action "necessary and advisable in the national interest" reflects Congressional intent to preclude judicial review under the federal Administrative Process Act, 5 U.S.C. §§ 701-706). The Boren Amendment, which provides that states must "find" that payment rates are "reasonable" and "adequate" enough to ensure access to care, similarly suggests that Congress intended to leave to the Secretary and the states the task of defining reasonableness in this context.

(Section 1116 of the Social Security Act) and the implementing regulations at 42 C.F.R. Part 430 and §§ 430.18 and 430.38 (1988). Furthermore, Congress directed the Secretary to develop an appropriate appeals procedure for health care providers. S.Rep. No. 1240, 94th Cong. 2d Sess., reprinted in 1976 U.S. Code Cong. & Admin. News 5648, 5649-51. In mandating state appeals procedures, the Secretary found that "States are in a better position to define or determine what is 'efficient and economical' for its [sic] Medicaid program. More importantly, we believe *any Federal attempt to impose specific definitions would unnecessarily intrude upon the legislatively mandated flexibility provided to States under the statute.*" 48 Fed. Reg. 56049 (1983) (emphasis added).

Federal administrative monitoring of state plans and state administrative and judicial review of payment systems were intended by Congress as the exclusive means to enforce the Medicaid Act. Particularly in light of the limited nature of the asserted underlying right — at most, a right to "findings" by the State and "assurances" to the Secretary — a system of state administrative and judicial review, coupled with periodic oversight by the Secretary, is entirely sufficient.

**B. The VHA describes incorrectly the providers' right to review under the Virginia Administrative Process Act.**

The VHA argues that Virginia law does not provide a remedy under which Medicaid providers can litigate reimbursement disputes. Resp. Br. 36-41. That argument is incorrect on its face. The authority cited by the VHA, Resp. Br. at 37, 38 n.34&35, obviously relates exclusively to recipient appeals and to judicial review of eligibility matters. Section 9-6.14:4.1(B)(4) of the Code of Virginia was enacted in 1989 expressly to provide state judicial review of individual eligibility case decisions, a fact the VHA later acknowledges.<sup>11</sup>

Moreover, the VHA ultimately cites Section 32.1-325.1 of the Code of Virginia (Supp. 1989), which was enacted after the decision in *Mary Washington Hospital v. Fisher*, 635 F.Supp. 891 (E.D.Va. 1985), to provide review of provider reimbursement disputes under the Virginia Administrative Process Act, §§ 9-6.14:1 - 9-6.14:25 of the Code of Virginia (1989). Resp. Br. at 38, n.36.

<sup>11</sup> Respondent's Brief at 35, n.35, discusses this statute at length, acknowledging that it was designed to deal with case decisions regarding the grant or denial of Medicaid benefits. It then suggests inconsistently "[i]f it is [the statute] that provides the basis for judicial review of state plans, . . . meaningful state judicial review would be unavailable."

This statutory process affords to providers, such as the VHA member hospitals, the full panoply of state administrative and judicial review. Acting under its statutory authority, the Virginia Medicaid program has established in the State Plan for Medical Assistance ("State Plan") extensive regulations dealing with hospital reimbursement. J.A. 24-45. This regulatory scheme includes the Prospective Payment System which defines how payments are determined for hospitals, and the Appeals System which provides a detailed procedure for resolution of payment disputes. Under the Appeals System, upheld in 1986 by the District Court in *Mary Washington, supra*, and again by the District Court in this case below, three distinct levels of administrative review are available.<sup>12</sup>

Thereafter, two levels of judicial review — to the Virginia circuit courts and to the Virginia Court of Appeals — are available as a matter of right. A third — to the Supreme Court of Virginia — is available by writ. Moreover, the Virginia Administrative Process Act, and § 9-6.14:17 of the Code of Virginia (1989) in particular, assures that the broadest range of factual and legal issues may be heard by the courts of the Commonwealth. These include constitutional, statutory, procedural and factual issues. Issues of federal, as well as state law, may be preserved and raised by providers on appeal whether or not the agency itself has the authority to address them.<sup>13</sup>

**III. A PRIVATE ACTION TO ENFORCE THE BOREN AMENDMENT IS NOT NECESSARY TO ENSURE THE INTEGRITY OF THE MEDICAID SYSTEM OR THE REASONABLENESS OF REIMBURSEMENT RATES**

The VHA contends that, unless the Boren Amendment is construed to afford an enforceable right for providers to reasonable rates, the states will be left "free to pay any amount they choose," thus rendering the statute "meaningless." Resp. Br. 18. That is not so. The premise of the Boren Amendment was that adequate rates could be most efficiently

<sup>12</sup> On October 24, 1989, the District Court once again granted summary judgment to the Commonwealth as to the Appeals System. The ruling was made from the bench and an order has not yet been formally entered.

<sup>13</sup> See e.g., *Bridgewater Home, Inc. v. Commonwealth of Virginia* (Va. App. Rec. No. 0885-87-4, July 22, 1988), a Medicaid provider dispute raising both federal and state issues.

secured by freeing the states from excessive federal scrutiny, which had "overburden[ed] the States and facilities with marginal but massive paperwork requirements." S. Rep. No. 471, *supra*, at 29. The idea was to promote state accountability — by requiring the *states* to find, and satisfactorily assure the *Secretary*, that their rates were sufficient.<sup>16</sup> That is one way — a reasonable and sensible way — of promoting Congress' goals in the Medicaid statute. The VHA offers another way, private suits to reexamine the absolute reasonableness of rates, but it is not the way chosen by Congress.<sup>17</sup> And, the VHA's professed concern about the efficacy of Congress' choice — that a state may decide "without limit, simply [to] adopt any reimbursement method it chose, and pay as little as it wished," Resp. Br. 18 — reflects a suspicion of state integrity and commitment to quality care that is not warranted by the record and, in

<sup>16</sup> We do not understand the VHA's suggestion, Resp. Br. 19, that we and the United States as amicus have somehow "ignore[d] the fact that the statute expressly requires, before any assurances are made to the Secretary, that a state find that its plan will produce reasonable and adequate rates." We recognize the obligation to make such findings and the VHA acknowledges that the Commonwealth has made the required findings in this case; our point, however, is that the obligation to make findings does not convert into an enforceable obligation to pay rates that providers believe to be reasonable.

<sup>17</sup> The VHA relies, Resp. Br. 16, 22, on this Court's recent decision in *Golden State Transit Corp. v. City of Los Angeles*, No. 88-840, slip. op. (Dec. 5, 1989), but that case affords cold comfort. In *Golden State*, the Court held that an employer could sue under Section 1983 for damages arising from a city's interference with its statutory rights under the National Labor Relations Act. The Court reasoned, from the text of the statute and the decisions construing it, that the NLRA was designed "to give parties to a collective-bargaining agreement the right to make use of 'economic weapons,' . . . free from governmental interference." *Id.* at 8. The Court concluded that "the interest in being free of governmental regulation of the 'peaceful methods of putting economic pressure upon one another,' . . . is a right specifically conferred on employers and employees by the NLRA." *Id.* at 9. It therefore held that the Act created "obligations 'sufficiently specific and definite' to be within the competence of the judiciary to enforce." *Id.* at 9.

*Golden State* is easily distinguishable. "[B]ased on the language, structure, and history of the NLRA," *id.* at 8, the Court found a well-demarcated cone of labor-management dispute within which government (federal and state) may not interfere. The terms of the right were clear-cut: provided the parties to a labor dispute use lawful "economic weapons," they are entitled to a regime of strict noninterference. *Id.* By contrast, the underlying right established by Section 1396a(a)(1)(B) is anything but "specific and definite." See *id.* at 5. At most, it entitles providers to insist on findings and assurances — obligations that the VHA concedes have been satisfied in this case.

any event, is not consistent with the Congressional design.<sup>18</sup> Senator Boren rejected this kind of argument as "simply fatuous." Boren Testimony at page 847, and so should this Court.

## CONCLUSION

For all of the reasons stated, the Commonwealth respectfully requests that the Court reverse the decision of the Court of Appeals.

Respectfully submitted,

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<sup>18</sup> For the same reason, the VHA errs in contending that it is "irrelevant," under our view of the statute, "[w]hether [the state's] 'assurances' are true or false." Resp. Br. 19. No one is suggesting that a state is entitled to shirk its duty to make appropriate findings or to give honest assurances to the Secretary. The question presented, however, is whether a statutory scheme that explicitly rests on a system of findings and assurances thereby creates enforceable rights in private parties under Section 1983. For the reasons we have stated, the answer is plainly no.